Overview of Hospital Payment Systems

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Medi-Cal Payment to Hospitals

- Medi-Cal pays a “per diem” rate hospitals
- A flat rate per day in a hospital

Medicare Payment to Hospitals

- Medicare pays “Diagnostic Related Groups”, or “DRG” rate to hospitals
- A flat rate per case admitted to a hospital

Private Payment to Hospitals

- In the old days, private plans pay hospitals by procedures
- “Fee-for-services” or “FFS”
- Payment based on “usual and customary” charges
- Hospitals develop their own “chargemaster” and update that frequently
- There is no systematic way of how hospitals update their charges

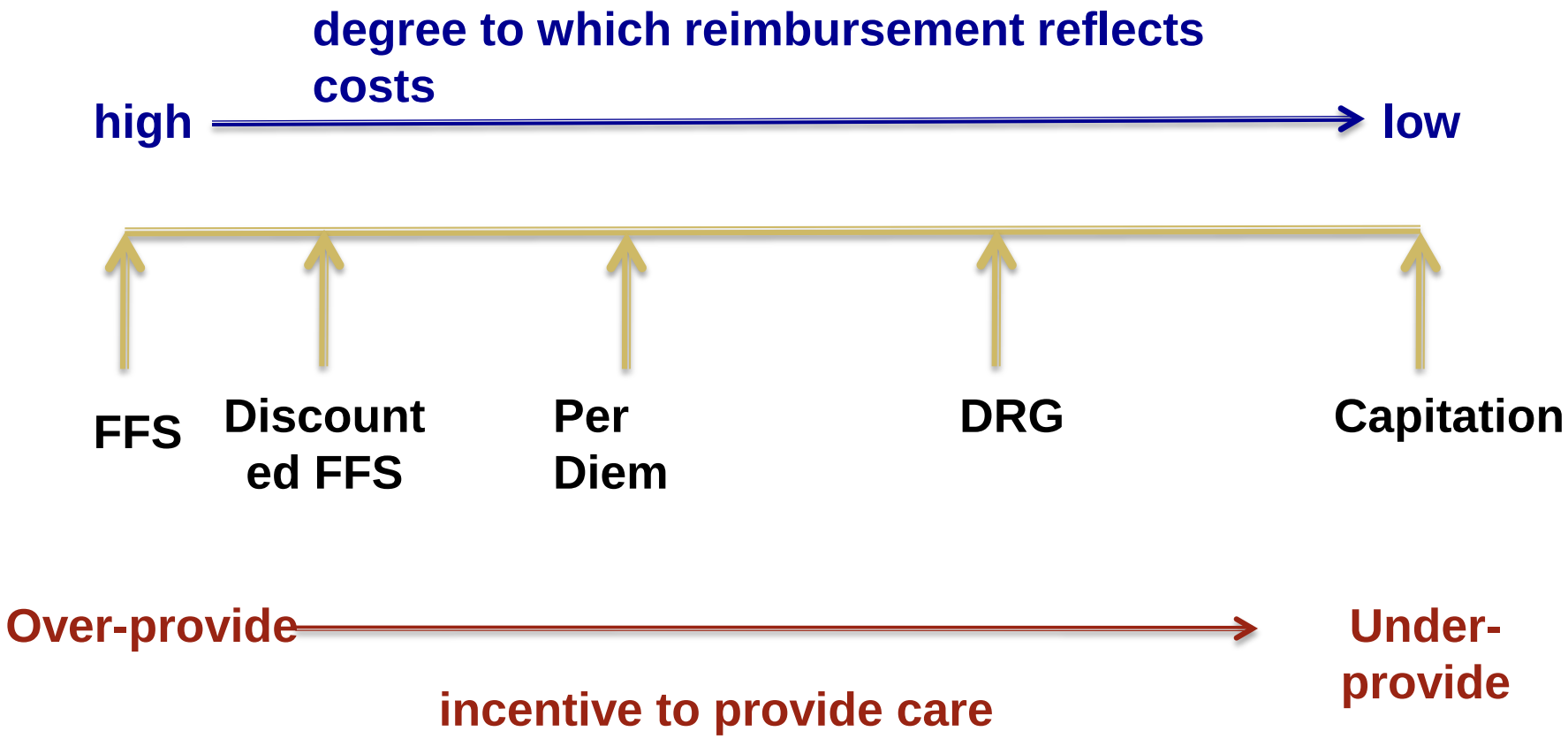
Private Payment to Hospitals

- Managed care rose since the 1980s
- Began to form network providers and pay differently
  - Discounted FFS - heavily discounted rates off "charges"
  - Per diem – a flat rate per day
  - DRG – a flat rate per admission, Medicare rates
  - Case rate - a flat rate per admission, private rates
  - Capitation – a flat rate per patient, all inclusive

Private Payment for Out-of-network Hospitals

- Chargemaster to hospitals is like appendix to human beings
  - It was once useful but is no longer functional today
- With 2 exceptions, where insurance contract is not binding
  - Hospitals bill uninsured full charges, until recently
  - Out-of-network hospitals bill plans full charges. Patients have to pick up what plans do not pay (except for emergency care)

Incentives Under Different Payment Methods



Issues Related to Switching from Per Diem to DRG

- Upcoding
  - Code patients toward DRGs that pay more
- Unbundling
  - Inpatient spending is reduced
  - Spending for non-hospital care increases (such as rehab, skilled nursing, and home health services)
- Cost-cutting vs cost-shifting
  - Lower DRG payments → hospitals cut cost, if they do not have market power
  - Lower DRG payments → hospitals raise payments for private plans, if they have market power

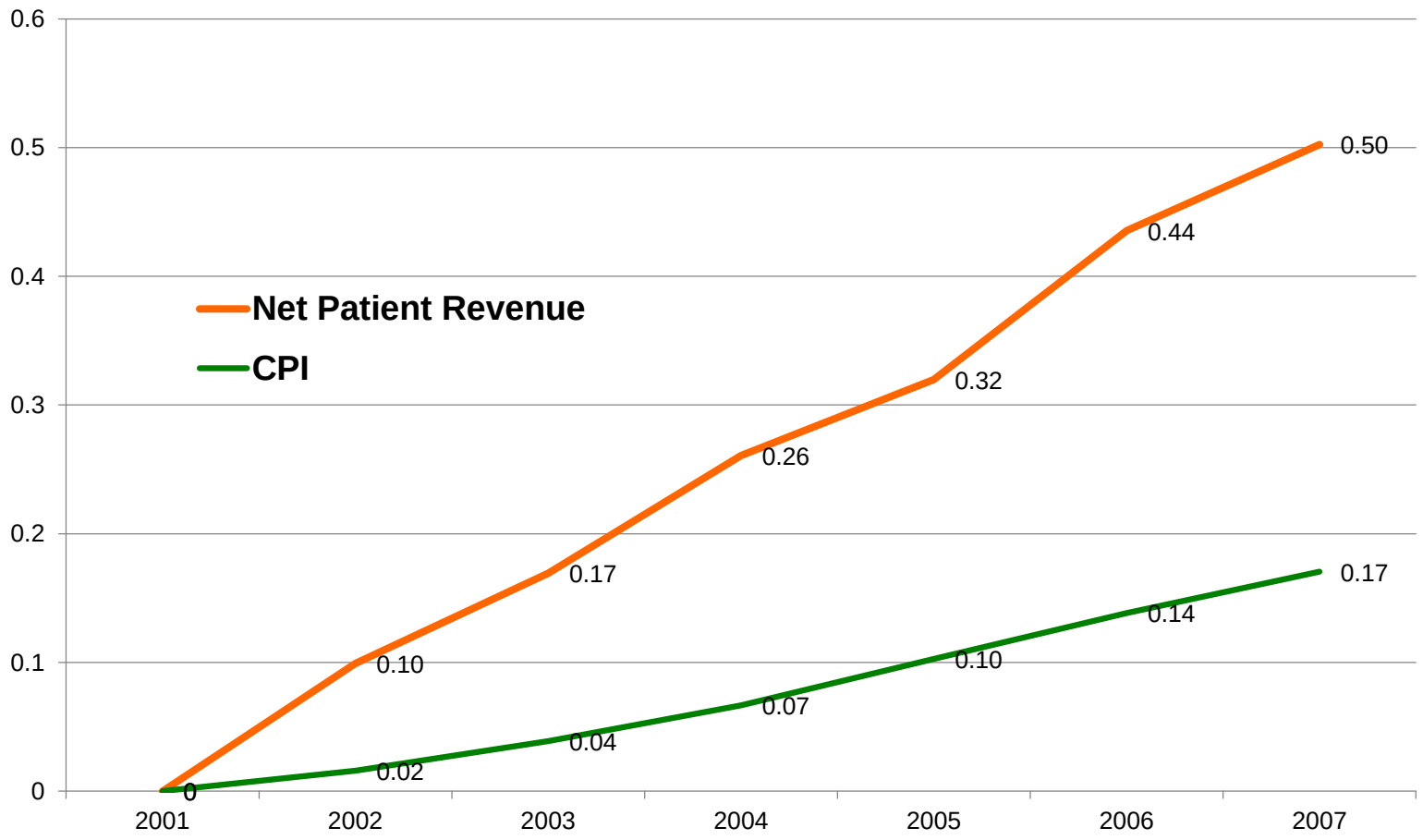
Issues Related to Switching from Per Diem to DRG

- Payment adequacy
  - Higher payment for high-cost cases (outlier payment)
  - Very low DRG payment may hurt access and quality of care provided to beneficiaries
- Pay for quality
  - DRG/prospective payment has not encouraged better quality

Major Reimbursement Issues in the Current Hospital Environment

- Hospital spending have been growing rapidly since 1999 (7% per year), unclear what the major drivers are
- Huge variation in prices paid to hospitals that is not related to cost or quality
- Some evidence that hospital market power is related to higher payments in several markets

Cumulative Growth in Hospital Payment, 2001-2007



Cost and Payment for Cardiac Valve Replacement Surgery in CA, 2008